Commonwealth of Virginia
Department of Social Services

Neighborhood Assistance Program
Services Contribution Data Sheet

(To be completed and submitted with the CNF-H)

(Print)

To Be Used For Donated Pharmaceutical Services provided at a 501(c) (3) Clinic at the direction of a NAP Organization

(Please use a separate form for each clinic)

NAME OF DONOR:	
ADDRESS:	
NAME OF NAP ORGANIZATION:	

Contact Info Of Clinic Where Services Were Provided		**DATE** (List each date separately)	**HOURLY RATE** (excludes fringes)	**TOTAL HOURS WORKED**	**TOTAL VALUE** (Rate x Hours)
Federal ID#:					
Name of 501(c) (3) Clinic					
Street Address of Clinic:					
City, State, Zip:					
Phone Number:					

NOTE: Other formats providing the same information will be accepted. **Sign and attach this form to the CNF or other format and return to the NAP Organization.**
CERTIFICATION BY PHARMACIST: I certify that the value of the donated service(s) was determined by the standards stated in the instructions and does not exceed the statutory maximum. I also certify I will not receive any type of compensation or reimbursement from medical insurance filing or from my company for the donated service(s) nor will my company receive any compensation. I understand that if I falsify information, I may be subject to penalties prescribed by the Virginia Departments of Taxation and Social Services.

Date

Signature of Donor